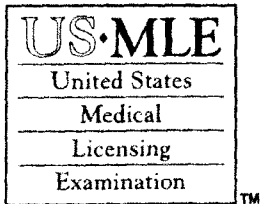


25



UNITED STATES MEDICAL LICENSING EXAMINATION™

Federation of State Medical Boards of the U.S., Inc.
P.O. Box 619850, Dallas, Texas 75261-9850
Telephone: (817) 868-4041

STEP 3 SCORE REPORT

Grant, Carrol Earl

Test Date: November 1, 2006

USMLE ID: 4-048-306-7

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. **Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

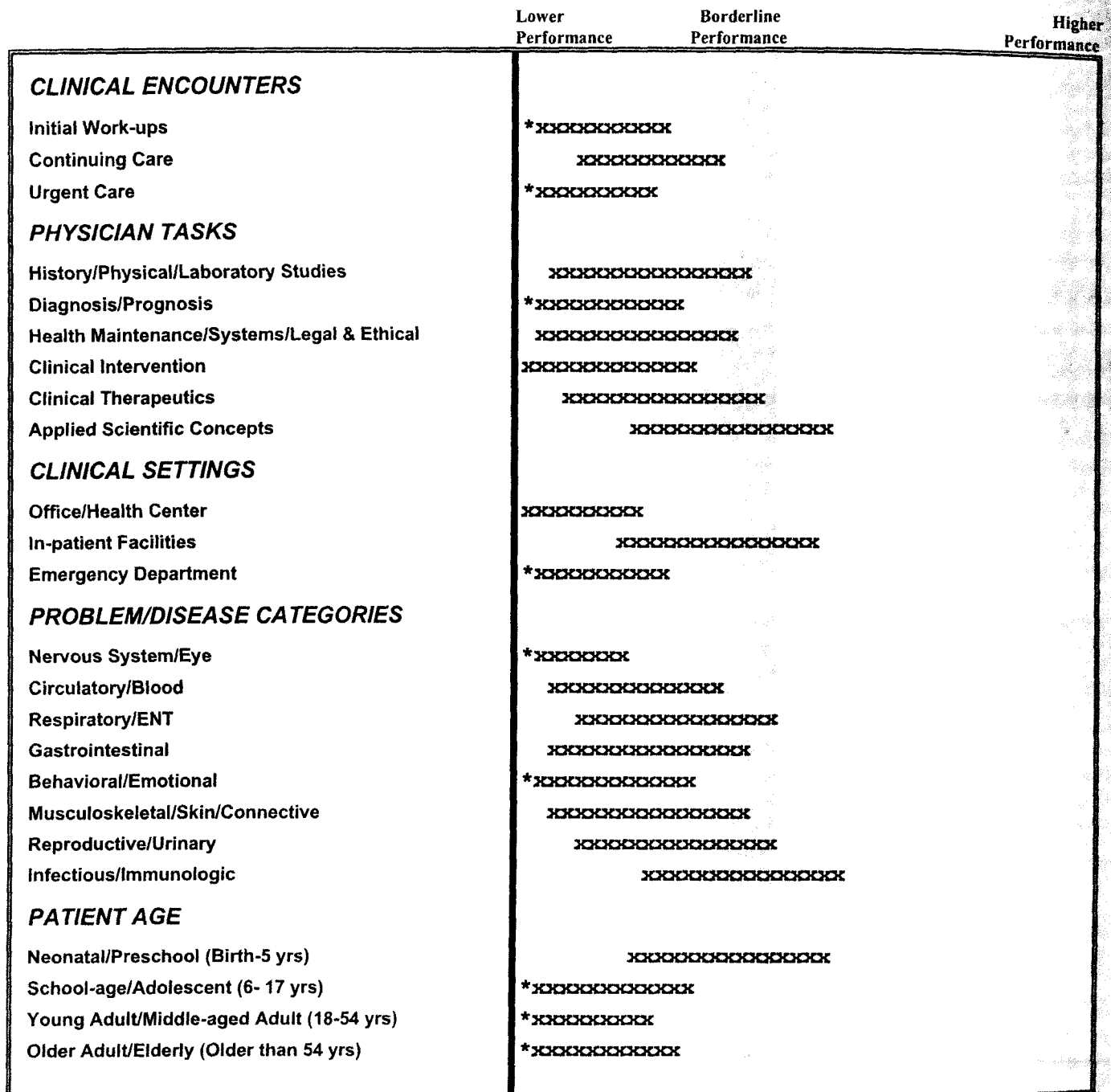
FAIL +	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.
161 +	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools were approximately 213 and 17, respectively, with most scores falling between 140 and 260. A score of 184 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM) [‡] for this scale is approximately seven points.
65 +	This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 184 on the scale described above, is recommended by USMLE to pass Step 3. The SEM [‡] for this scale is approximately three points.

+Following review and approval of your written request, testing accommodations were provided during the administration of this examination. A similar annotation will be included on your USMLE transcript.

‡Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

INFORMATION PROVIDED FOR EXAMINEE USE ONLY

The Performance Profile below is provided solely for the benefit of the examinee. These profiles are developed as assessment tools for examinees only and will not be reported or verified to any third party.

USMLE STEP 3 PERFORMANCE PROFILES

The above Performance Profile is provided to aid in self-assessment. The shaded area defines a borderline level of performance for each content area; borderline performance is comparable to HIGH FAIL / LOW PASS on the total test.

Performance bands indicate areas of relative strength and weakness. Some performance bands are wider than others. The width of a performance band reflects the precision of measurement: narrower bands indicate greater precision. The band width for a given content area is the same for all examinees. An asterisk indicates that your performance band extends beyond the displayed portion of the scale. Small differences in the location of bands should not be over interpreted. If two bands overlap, the performance in the associated areas should be interpreted as similar.

Descriptions of the topics covered in these content areas can be found in the informational materials for USMLE Step 3.

To apply or reapply for USMLE Step 3:

To apply or reapply for USMLE Step 3, you must have achieved a passing score on Step 1 and Step 2 CK, graduated from medical school, and met any additional requirements set by the medical licensing authority to which you are applying. In addition, depending on your graduation date or upon the date by which you take and pass Step 2 CK, you may also be required to pass Step 2 CS before registering for Step 3. More specific information about Step 3 requirements, registration, and licensure is available on the web site for the Federation of State Medical Boards (FSMB) (<http://www.fsmb.org>), by calling the FSMB at 817-868-4041, or by contacting the medical licensing authority where you intend to apply for licensure. Addresses and telephone numbers for the individual licensing authorities are found on the FSMB web site and in the current *USMLE Bulletin of Information*.

You may retake a Step 3 examination **only** if your score is below that required to pass or to comply with a time limit for completion of all three Steps or with other criteria established by the medical licensing authorities. You may retake Step 3 no less than 60 days after failing that Step and no more than three times within a 12-month period.

Federation of State Medical Boards
P.O. Box 619850
Dallas, Texas 75261-9850

FIRST-CLASS MAIL
U.S. POSTAGE
PAID
Philadelphia, PA
Permit No. 2126

FORWARDING SERVICE REQUESTED

FIRST-CLASS MAIL

4-048-306-7

GRANT, CARROL EARL
13805 155TH PLACE NORTH
JUPITER, FL 33478

FIRST-CLASS MAIL

26

RECEIVED SEP 01 2004

HHC 18th MEDCOM
Unit # 15281, Box # 872
APO, AP 96205-5281
August 30, 2004

ATTN: Mr. Brian Wilsford
Exam Dept/Step 3
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039

Dear Mr. Wilsford:

Enclosed, is my signed notarized application for the 2004 USMLE Step 3 examination. The fee for the examination is paid through your online application process.

I have received your recent report indicating that I received a failing grade. I hereby formally request that a hand-scoring of the USMLE examination that I took on July 21- 23, 2004, be done immediately and the result forwarded to me at the above address.

I am enclosing a check in the amount of \$25.00, the required fee for the hand-scoring. I anticipate a formal reply within the projected time frame stipulated in your information Bulletin.

Respectfully,


Dr. C. Earl Grant

40483067

7/21/04 0401 31

sent 8/18

Cutoff: 11/16/04

grant9653@
netscape.net

27



FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.

October 28, 2004

C Earl Grant
HHC 18th MEDCOM
Unit 15281, Box 872
APO, AP 96205-5281
USA

RE: Request for recheck of USMLE Step 3

Date of Exam: 7/21/04

USMLE ID#: 40483067

State of Exam: FL

Dear Dr. Grant:

In accordance with your written request, we have rechecked your 7/21/04 USMLE Step 3 as referenced above. The results are as follows:

The scores were found to be accurate as originally reported.

If we may be of further assistance, please feel free to contact us at (817) 868-4041.

Sincerely,

Sandy McAllister
Administrative Assistant
Examination Services

CC: Larry McPherson, Esq, Executive Director (FL)

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UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)

2003 STEP 3 APPLICATION

For applications submitted to FSMB by September 1, 2003

Refer to the Application Instructions when completing this form. Complete all three pages. Type or print in uppercase block letters. Use black ink only.

1. LICENSING AUTHORITY FOR WHICH STEP 3 IS BEING TAKEN See Instructions for Board Code.	<div style="border: 1px solid black; padding: 2px; display: inline-block;">036</div>	State Medical Board of Ohio <small>Board Code Name of Licensing Authority whose requirements you are using to apply for Step 3.</small>												
2. FEE ENCLOSED See Medical Licensing Board Instruction Sheet for fee.	\$ <u>590.00</u> U.S. DOLLARS (non-refundable fee)													
3. NAME Print your name exactly as it appears on the unexpired, government-issued identification you plan to present at the test center. See Instructions, "Completing Your Application."	<div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">G R A N T</div> <small>LAST (Surname) and Suffix</small> </div> <div style="width: 50%;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">C A R R O L E A R L</div> <small>FIRST and Middle Name(s)</small> </div> </div> <div style="margin-top: 5px;"> If you have applied previously under another name for any examination listed in Item 11 below, please provide that name and a copy of the legal document which verifies this change. <div style="text-align: center; margin: 5px 0;">N/A</div> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"><small>Last</small></div> <div style="width: 30%;"><small>First</small></div> <div style="width: 30%;"><small>Middle</small></div> </div> </div> </div>													
4. DATE OF BIRTH Indicate month as shown: Jan-01; Feb-02; Mar-03; Apr-04; May-05; Jun-06; Jul-07; Aug-08; Sep-09; Oct-10; Nov-11; Dec-12	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">09</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">16</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1953</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH DAY YEAR </div>													
5. U.S. SOCIAL SECURITY AND NATIONAL IDENTIFICATION NUMBERS Enter your S.S. Number and/or the official number assigned by your country if outside the U.S. See Instructions for Country Code.	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">416</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">04</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">9575</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> U.S. Social Security Number National Identification Number </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">Country Code</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">Issuing Country</div> </div>													
6. GENDER	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female													
7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL See Instructions for Country Code.	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">099</div> <div>United States of America</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> Country Code Name of Country </div>													
8. MEDICAL EDUCATION See Instructions for Country Code. Graduation Date— Indicate month as shown: Jan-01; Feb-02; Mar-03; Apr-04; May-05; Jun-06; Jul-07; Aug-08; Sep-09; Oct-10; Nov-11; Dec-12	Medical School of Graduation <u>University of Minnesota</u> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">099</div> <div>USA</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">06</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1999</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> Country Code Country of Medical School Graduation Date MONTH YEAR </div> Degree: <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other (specify): _____ If school is outside the U.S. or Canada: ECFMG Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date issued: ____/____/____ 5th Pathway Program: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date completed: ____/____/____ <div style="margin-top: 10px;"> <div style="border: 1px solid black; padding: 5px; display: inline-block;"> FOR OFFICE USE ONLY </div> <table style="margin-left: 10px; font-size: small;"> <tr> <td></td> <td>SCC</td> <td>Y</td> <td>N</td> </tr> <tr> <td>DEGREE</td> <td>Y <u>N</u></td> <td>5th PATHWAY</td> <td>Y N</td> </tr> <tr> <td>ECFMG</td> <td>Y N</td> <td>EXAM PREREQUISITES</td> <td><u>Y</u> N</td> </tr> </table> </div>			SCC	Y	N	DEGREE	Y <u>N</u>	5th PATHWAY	Y N	ECFMG	Y N	EXAM PREREQUISITES	<u>Y</u> N
	SCC	Y	N											
DEGREE	Y <u>N</u>	5th PATHWAY	Y N											
ECFMG	Y N	EXAM PREREQUISITES	<u>Y</u> N											

NAME C. EARL GRANT

10. SPECIALTY See Instructions for Specialty Code.	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 10px;">07</div> <div>Internal Medicine</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> Specialty Code Name of Specialty or Planned Specialty </div>									
11. EXAMINATION IDENTIFICATION NUMBERS Indicate the examinations for which you have applied.	<p>Identification Number (If Known)</p> <p>ECFMG </p> <p>FLEX </p> <p>NBME </p> <p>USMLE 4 - 0418 - 306 - 7</p>									
12. USMLE PASSED Record the administration date of each examination passed and the number of attempts. Date Passed - Indicate month as shown: Jan-01; Feb-02; Mar-03; Apr-04; May-05; Jun-06; Jul-07; Aug-08; Sep-09; Oct-10; Nov-11; Dec-12	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Examination</th> <th style="width: 40%;">Date Passed</th> <th style="width: 40%;"># of Attempts</th> </tr> </thead> <tbody> <tr> <td>USMLE Step 1</td> <td style="text-align: center;"> 06 19 99 04 </td> <td style="text-align: center;"> 04 </td> </tr> <tr> <td>USMLE Step 2</td> <td style="text-align: center;"> 03 19 99 04 </td> <td style="text-align: center;"> 04 </td> </tr> </tbody> </table> <div style="display: flex; justify-content: space-around; font-size: x-small;"> MONTH YEAR </div>	Examination	Date Passed	# of Attempts	USMLE Step 1	06 19 99 04	04	USMLE Step 2	03 19 99 04	04
Examination	Date Passed	# of Attempts								
USMLE Step 1	06 19 99 04	04								
USMLE Step 2	03 19 99 04	04								
13. ADDRESS This address will be used for correspondence regarding registration for Step 3. Print your current mailing address. If you provide an address outside the U.S., correspondence relating to Step 3 may be significantly delayed. Provide a U.S. address, if possible. If your address changes or is different for score reporting, see Instructions, "Change of Address." See Instructions for Country Code.	<p>Address Line 1 P O B O X 5192</p> <p>Address Line 2 </p> <p>Address Line 3 </p> <p>City Fairlawn State/Province OH</p> <p>Country Country Code </p> <p>ZIP/Postal Code 44334 - Daytime Telephone Number 3303446000 ext 2155</p> <p>Email Address grant915@white.com</p>									
14. TEST ACCOMMODATIONS Check this box if you are requesting test accommodations.	<input checked="" type="checkbox"/> I have a documented disability covered under the American with Disabilities Act and am requesting test accommodations. (Checking this box does not constitute an official request. You must submit your request for test accommodations and accompanying documentation at the same time as this application. See Instructions, "Applying for Test Accommodations.")									
15. DATA RELEASE Release of Step 3 Data	<p>The NBME reports USMLE total scores to LCME- and AOA-accredited medical schools for their students and graduates. This data is used by the schools to monitor the outcome of their educational process and as part of ongoing quality improvement activities. Only a total score is provided. If you do not wish to have your Step 3 score reported to your medical school of graduation, please check the box provided to the left.</p> <p><input checked="" type="checkbox"/> Only a total score is provided. If you do not wish to have your Step 3 score reported to your medical school of graduation, please check the box provided to the left.</p>									
16. SIGNATURE Review the Bulletin of Information before signing this statement. Note: If your application is not complete, signed and notarized as instructed, your registration will be delayed.	<p>I certify that I currently meet the Step 3 eligibility requirements, that the information provided on this form is true and accurate, and that I have provided all required documentation. I also certify that I have read the 2003 USMLE Bulletin of Information and the application instructions, that I am familiar with their contents, and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 to verify my eligibility and, if a USMLE transcript is required by that authority, I agree to pay the applicable transcript fee. I agree that my Step 3 score may be released to the medical licensing authority for which I am taking Step 3.</p> <p>Applicant Signature <u>C. Earl Grant</u> Date <u> </u> / <u> </u> / <u> </u> MO DY YR</p>									

Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information. The processing of your application will not be affected by your choice in this regard.

Select the 1 option which best describes your racial/ethnic

☐ 1 American Indian/Alaskan Native
 ☐ 2 Asian
 ☐ 3 Native Hawaiian or other Pacific Islander
 ☐ 4 Hispanic or Latino
 ☒ 5 Black or African American
 ☐ 6 White
 ☐ 7 Other

Is English your native language?

☒ Yes
 ☐ No

UNITED STATES MEDICAL LICENSING EXAMINATION™
2003 STEP 3 APPLICATION

4-048-306-7

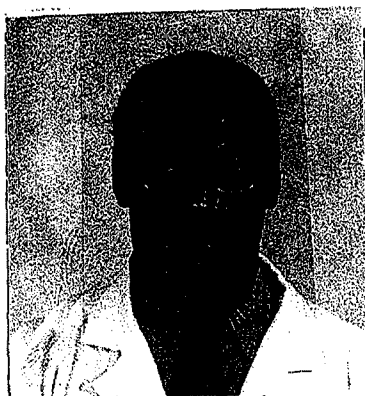
USMLE IDENTIFICATION NO.

Type or print in uppercase block letters. Use black ink only.

Name GRANT, C. EARL
 Last First Middle

S.S./N.I. Number 416-04-9575 Date of Birth 09 / 16 / 1953 Gender ☒ Male ☐ Female
 Month Day Year

Licensing authority for which Step 3 is being taken STATE MEDICAL BOARD OF OHIO



C. Earl Grant

Applicant Signature

By my signature above, I certify that all of the information provided on this form is true and accurate.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required.

State of OHIO County of Summit

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 20th day of DECEMBER, 2002.

Notary Public Signature

Charleen E. King

Expiration Date 09 / 18 / 2006
 Month Day Year

CHARLEEN E. KING, Notary Public
 Residence - Stark County
 State Wide Jurisdiction, Ohio
 My Commission Expires Sept. 18, 2006

Federation of State Medical Boards
P.O. Box 619850 Dallas, TX 75261-9850
Telephone (817) 868-4041

RECEIVED FEB 28 2003

USMLE STEP 3

CERTIFICATION OF POST-GRADUATE TRAINING - Ohio

This section is to be completed by the applicant and forwarded directly to the Program Director. (PRINT)

Note: It facilitates processing when the PGT form accompanies the Step 3 application. PGT form(s) received more than 45 days before receipt of the application are not considered current and will not be accepted.

USMLE ID # 40483067 Date of Birth 9-16-1953 SS# 416-04-9575

Physician Name C. LEARL GRANT

(PLEASE PRINT - Last Name, First Name, Middle Name)

Hospital Name AKRON GENERAL MEDICAL CENTER

City AKRON State OH Phone # 330 664 0979

I hereby authorize the release of all pertinent information, favorable or otherwise, to FSMB.

Signature C. Earl Grant

Date 2/19/2003

This section is to be completed by the Program Director, notarized, and forwarded directly to the FSMB at the above address by September 1, 2003 for the 2003 USMLE Step 3. (PLEASE PRINT)

I certify that the physician named above is serving / has served 20 (CIRCLE ONE) months / years of post-graduate training (CIRCLE ONE) at the hospital named above, as indicated below: (please check one)

- ☒ internship or residency program accredited by the ACGME or AOA
☐ a clinical fellowship in the US at an institution having an accredited residency program in the same or a related field
☐ an internship in Canada accredited by the committee on accreditation of pre-registration physician training programs of the Federation of Provincial Medical Licensing Authorities in Canada
☐ a residency program in Canada accredited by either the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)

Date post-graduate training began / will begin: 7 / 01 / 2001
 (CIRCLE ONE) MONTH DAY YEAR

Date post-graduate training was / will be completed: 2 / 17 / 2003
 (CIRCLE ONE) MONTH DAY YEAR

Please evaluate applicant's competence and conduct during the program: (Use additional paper as necessary.)

See Attached Documentation.

This program has had cause to take adverse action against this applicant's participation (restriction, suspension, termination, requested resignation, etc.) ☒ YES ☐ NO If yes, explain: (Use additional paper as necessary.)

Signature of Program Director James E. Hodsdon, MD

Print Name of Program Director

Date 2/21/03

Sworn to and subscribed before me on this the 21st day of February, 2003.

Signature of Notary Public Willie Walker

Date Commission Expires May 6, 2004

NOTARY
STAMP HERE

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USMLE	ExamFile
4-048-306-7	404-83-06
State	010
User	DAJ
req_id	13241309
web	26244
daterec	04/11/04
Name	Carrol Earl Grant
SSN	416049575
DOB	09/16/53
Grad Date	Jun-99
PB	JSJ
datecreated	04/12/04

Monday, April 12, 2004

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDRDB			
File	Edit	Fee	Additional Info
Name	Grant	Batch ID	Seq. No. Req. ID 13241309
Name	Carrol Earl		
Application Information - 1		Application Information - 2	
1.	State Board	Florida Board of Medicine	Assign User
	App Date	App Date Type	Exam Code
2.	Attach	F&B	
3.	Last Name		
	Rest Of Name	Carrol Earl	
	Generational Suffix		
4.	Date of Birth	09	16
		1993	(mm/dd/yyyy)
5.	US Social Security No.	A36849575	
	National ID Number		
	National ID Country	List	
6.	Gender	M	
7.	Citizenship Cntry	List	USA
8.	Med. School of Grad.	List	024030
		University of Minnesota Medical School - Minneapolis	
	Med. Sch. Country	List	USA
	Degree Code	Doctor of Medicine	
	Graduation Month/Year	06	1999
Full Service - Page 1			
USMLE Step 3 Full Service Application Page 2 - V4.02.015- PDRDB			
File	Edit	Fee	Additional Info
Name	Grant	Batch ID	Seq. No. Req. ID 13241309
Name	Carrol Earl		
Application Information - 1		Application Information - 2	
9.	Participation Flag	Future Start Date Month/Year	Date Program Started Month/Year
	Yrs Completed	From Month/Year	To Month/Year
	Program Code	Internal Medicine	
10.	Specialty Code	A - Internal Medicine	
11.	Identification Numbers		
	ECFMG		
	FLEX		
	NBME		
	USMLE	40497067	
13.	Address Line1	Delta Co 166th MED BN Unit 15921	
	Address Line2	Box 5APO AE 96218	
	Address Line3	13005-155th Place N	
	City	State/Prov	Zip/Postal Code
	Jupiter	FL	33478
	Country	List	USA
	Phone	011921196850210	
	E-mail	grant9653@net.scaps.net	
15.	Ethnic Background	English Native Language	
14.	<input checked="" type="checkbox"/> Release of Step 3 data - Applicant does NOT wish to have scores reported to their school. <input checked="" type="checkbox"/> Test Accommodations - Applicant requested for Test Accommodations. <input type="checkbox"/> Request Practice CD - Applicant requested for Practice CD to be mailed to them.		
16.			
Full Service - Page 2			

UNITED STATES MEDICAL LICENSING EXAMINATION™

RECEIVED APR 26 2004

2004 STEP 3 SIGNATURE/PHOTO ID PAGE

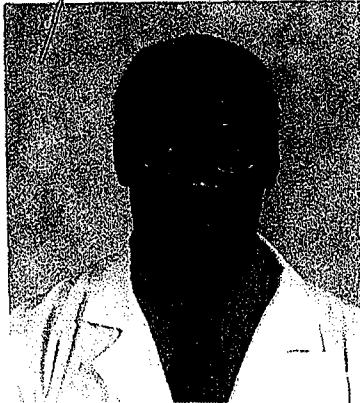
Web Req
ID:

26244

USMLE ID:

4-048-306-7

Type or print in uppercase block letters. Use black ink only.



Name:

Grant, Carrol Earl

Last

First

Middle

416049575

9/16/1953

S.S.N.I. Number

Date of Birth

Month Day Year

Gender ☐ Male ☐ Female

Licensing authority for which Step 3 is
being taken:

Florida Board of Medicine

I certify that I currently meet the Step 3 eligibility requirements and that the information provided on this form is true and accurate including the affixed photo of myself. I also certify that I have read the 2004 USMLE Bulletin of Information and all relevant application instructions, that I am familiar with their contents, and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 to verify my eligibility and, if a USMLE transcript is required by that authority, I agree to pay the applicable transcript fee. I agree that my Step 3 score may be released to the medical licensing authority for which I am taking Step 3.

Applicant Signature

C. Earl Grant, M.D.

Date

19 - April - 04

CERTIFICATION OF IDENTIFICATION
Certification by Notary Public is Required.

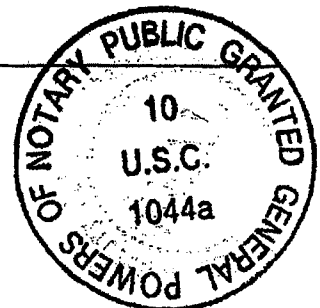
State of

CAMP HENRY

County of

KOREA

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 19th day of April, 2004.

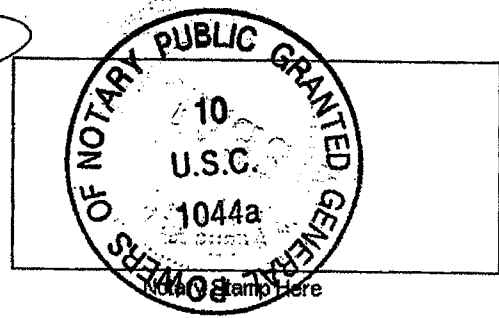


Notary Public Signature


AUTHORITY: 10 U.S.C. 936 & 1044a

Expiration Date* Commission Indefinite Until
Retirement or Resignation

*** The notary's commission expiration date must be current and legible.**



30

USMLE	4-048-306-7	ExamFile	404-83-06
State	010		
User	DAJ		
req_id	14387056		
web	40849		
daterec	08/31/04		
Name	Carrol Earl Grant		
SSN	416049575		
DOB	09/16/53		
Grad Date	Jun-99		
PB	RDB		
datecreated	09/01/04		

5

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDRDB			
File Edit Fee Additional Info			
Name Grant Carol Earl		Batch ID	Seq. No Req. ID 14387056
Application Information - 1		Application Information - 2	
1.	State Board	Florida Board of Medicine	Assign User
	App Date	App Date Type Web	Exam Code
2.	Attach	File	
3.	Last Name		
	Rest Of Name	Carol Earl	
	Generational Suffix		
4.	Date of Birth	09 16 1953 (mm/dd/yyyy)	
5.	US Social Security No.	316049375	
	National ID Number		
	National ID Country	List	
6.	Gender	M	
7.	Citizenship Cntry	List	099 USA
8.	Med. School of Grad	List	02443D
		University of Minnesota Medical School - Minneapolis	
	Med. Sch. Country	List	099 USA
	Degree Code	04	Doctor of Medicine
	Graduation Month/Year	06 1999	
Exit Cancel Review			
Full Service - Page 1			
USMLE Step 3 Full Service Application Page 2 - V4.02.015- PDRDB			
File Edit Fee Additional Info			
Name Grant Carol Earl		Batch ID	Seq. No Req. ID 14387056
Application Information - 1		Application Information - 2	
9.	Participation Flag	Future Start Date Month/Year	Date Program Started Month/Year
	Yrs Completed	From Month/Year 06 1999	To Month/Year 06 2002
	Program Code	10	Internal Medicine
10.	Specialty Code		
11.	Identification Numbers		
	ECFMG		
	FLEX		
	NBME		
	USMLE	40481067	
13.	Address Line1	13805 155th Place North	
	Address Line2		
	Address Line3		
	City	Jupiter	State/Prov FL Zip/Postal Code 33478
	Country	List	099 USA
	Phone	011821196850210	E-mail grant9053@net scape .net
15.	Ethnic Background	English Native Language	
14.	<input checked="" type="checkbox"/> Release of Step 3 data - Applicant does NOT wish to have scores reported to their school.		
16.	<input checked="" type="checkbox"/> Test Accommodations - Applicant requested for Test Accommodations.		
	<input type="checkbox"/> Request Practice CD - Applicant requested for Practice CD to be mailed to them.		
Exit Cancel Review			
Full Service - Page 2			

UNITED STATES MEDICAL LICENSING EXAMINATION™

2004 STEP 3 SIGNATURE/PHOTO ID PAGE

Web Req
ID: 26244

USMLE ID: 4-048-306-7

RECEIVED SEP 01 2004



Type or print in uppercase block letters. Use block ink only.

Name: Grant, Carol Earl
Last First Middle
SSN: 416049575 Date of Birth 9/16/1953 Gender ☒ Male ☐ Female
Month Day Year
Licensing authority for which Step 3 is being taken: Florida Board of Medicine

I certify that I currently meet the Step 3 eligibility requirements and that the information provided on this form is true and accurate including the affixed photo of myself. I also certify that I have read the 2004 USMLE Bulletin of Information and all relevant application instructions, that I am familiar with their contents, and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 to verify my eligibility and, if a USMLE transcript is required by that authority, I agree to pay the applicable transcript fee. I agree that my Step 3 score may be released to the medical licensing authority for which I am taking Step 3.

Applicant Signature [Signature] Date Aug 30, 2004

WITH THE US ARMED FORCES
AT SEOUL, KOREA

CERTIFICATION OF IDENTIFICATION
Certification by Notary Public is Required.

State of _____ County of _____

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 30 day of August, 2004.

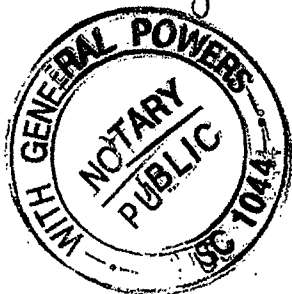
Notary Public Signature Military Notary

Expiration Date 11/11/11

*The notary's commission expiration date must be current and legible.

Notary Stamp Here

Jason T. Lowder
SGT, U.S. Army
Paralegal WCO
Military Notary



31

USMLE	4-048-306-7	ExamFile	404-83-06
State	010		
User	DAJ		
req_id	15385083		
web	63542		
daterec	03/19/05		
Name	Carrol Earl Grant		
SSN	416049575		
DOB	09/16/53		
Grad Date	Jun-99		
PB	JSJ		
datecreated	03/21/05		

Circle or Check off list	
Check for Data entry USMLE number _____	
Degree Verified	Yes or No
5th Pathway	ECFMG Yes or No
Exam file # Entered and Correct with file at top/side and USMLE # _____	
Check for Registration Initials _____	
Passed Step 1 and Step 2 Yes or No	
Check Loose Documents _____	
Previous valid CIF _____	
Notes	

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDRDB									
File		Edit		Fee		Additional Info			
Name		Grant		Batch ID		Seq. No.		Req. ID 15385083	
Name		Carrol Earl							
Application Information - 1					Application Information - 2				
1.		State Board		Florida Board of Medicine		Assign User			
		App Date		App Date Type		Exam Code			
2.		Attach		F20					
3.		Last Name							
		Rest Of Name		Carrol Earl					
		Generational Suffix							
4.		Date of Birth		09 16 1953 (mm/dd/yyyy)					
5.		US Social Security No.		X16049575					
		National ID Number							
		National ID Country		List					
6.		Gender		M					
7.		Citizenship Cntry		List		099		USA	
8.		Med. School of Grad.		List		024030			
						University of Minnesota Medical School - Minneapolis			
		Med. Sch. Country		List		099		USA	
		Degree Code		MD		Doctor of Medicine			
		Graduation Month/Year		06 1999					
<div>Exit</div> <div>Cancel</div> <div>Save</div>									
Full Service - Page 1									
USMLE Step 3 Full Service Application Page 2 - V4.02.015- PDRDB									
File		Edit		Fee		Additional Info			
Name		Grant		Batch ID		Seq. No.		Req. ID 15385083	
Name		Carrol Earl							
Application Information - 1					Application Information - 2				
9.		Participation Flag		X		Future Start Date Month/Year		Date Program Started Month/Year	
		Yrs Completed		3		From Month/Year		To Month/Year	
		Program Code		16		Internal Medicine		06 2002	
10.		Specialty Code		07		A - Internal Medicine			
11.		Identification Numbers							
		ECFMG							
		FLEX							
		NBME							
		USMLE		40481067					
13.		Address Line1		1000 18th MED CON					
		Address Line2		Unit 13283 Box 872					
		Address Line3							
		City		App		State/Prov		AP Zip/Postal Code	
								96205 List	
		Country		List		099		USA	
		Phone		011821106050216		E-mail		grant965@excite.com	
15.		Ethnic Background		10		Do not wish to respond		English Native Language	
								X	
14.									
16.									
<div>Exit</div> <div>Cancel</div> <div>Save</div>									
Full Service - Page 2									

UNITED STATES MEDICAL LICENSING EXAMINATION™
2005 STEP 3 APPLICATION
CERTIFICATION OF IDENTITY

RECEIVED MAR 30 2005

Web Req ID: 63542

USMLE ID: 4-048-306-7

This form must be signed by a notary public/commissioner of oaths. When completed and submitted to the Federation, this form becomes part of your USMLE record and will be used to identify you when you interact with the Federation if you need to re-apply for the Step 3. This Certification of Identity is valid for this and any subsequent Step 3 applications submitted to the Federation within a period of five years from the date of the applicant's signature. If you do not sit for this administration of Step 3 or must retake Step 3, it is not necessary to submit another Certification of Identity as long as this 2005 form is on file with the Federation of State Medical Boards and has not expired. (Note: Forms prior to 2005 cannot be substituted for this form.)

Type or print in uppercase block letters. Use black ink only.



Name: Grant Carol Earl
Last First Middle
S.S./I.I. Number 416-04-9575 Date of Birth 09 / 16 / 1953 Gender ☒ Male ☐ Female
Month Day Year

Licensing authority for which Step 3 is being taken:

Florida Board of Medicine FL

I certify that I am the individual named above, am represented in the attached photograph and that the signature below is my signature. I certify that I meet the eligibility requirements for Step 3 and that the information on this form is true and accurate. I also certify that I have read the most current version of the USMLE Bulletin of Information and all relevant instructions for this or any subsequent Step 3 application, that I am familiar with the contents of the Bulletin and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 and agree that my subsequent Step 3 score may also be released to the medical licensing authority.

Applicant Signature Carol Earl Grant

CERTIFICATION OF IDENTIFICATION
Certification by Notary Public Is Required.

State of Florida County of West Palm Beach I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 08 day of March, 2005.

Kathryn D. Holderman
PFC KATHRYN D. HOLDERMAN
PARALEGAL, US ARMY
LEGAL ASSISTANCE

Notary Public Signature

Expiration Date

INDEFINITE

The notary's commission expiration date must be current and legible.

WITH THE US ARMED FORCES
AT SEOUL, KOREA

Notary Stamp Here

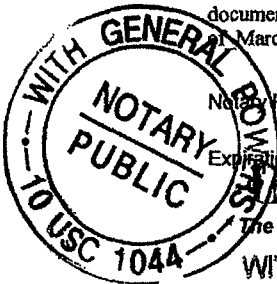
Please complete and mail this photo/ID page to:

Federation of State Medical Boards

Attn: Exam Services

400 Fuller Wiser Road, Suite 300

Euless, TX 76039



32

USMLE	4-048-306-7	ExamFile	404-83-06
State	033		
User	AMP		
reg_id	16325223		
web	90725		
daterec	11/21/05		
Name	Carrol Earl Grant		
SSN	416049575		
DOB	09/16/53		
Grad Date	Jun-99		
PB	DSV		
datecreated	11/22/05		

Circle or Check off list	
Check for Data entry USMLE number	<input checked="" type="checkbox"/> Yes or <input type="checkbox"/> No
Degree Verified	<input checked="" type="checkbox"/> Yes or <input type="checkbox"/> No
5th Pathway	ECFMG Yes or No
Exam file # Entered and Correct with file at top/side and USMLE #	<input checked="" type="checkbox"/>
Check for Registration Initials	
Passed Step 1	Step 2CK
Step1/ 2CK after 7/1/05	Step 2 CS
2005 grads	Step 2 CS
IMGs	Step 2CS or CSA
Check Loose Documents	<input checked="" type="checkbox"/>
Previous valid CIF	<input type="checkbox"/>
Notes	

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDRDB			
File Edit Fee Additional Info			
Name	Grant	Batch ID	Seq. No. Req. ID 16325223
Name	Carrol Earl		
Application Information - 1		Application Information - 2	
1.	State Board	New York State Board for Medicine	Assign User
	App Date	App Date Type	Exam Code
2.	Attach	File	
3.	Last Name		
	Rest Of Name	Carrol Earl	
	Generational Suffix		
4.	Date of Birth	09	16 1953 (mm/dd/yyyy)
5.	US Social Security No.	415040573	
	National ID Number		
	National ID Country	List	
6.	Gender	M	
7.	Citizenship Cntry	List	099 USA
8.	Med. School of Grad.	List	024030
		University of Minnesota Medical School - Minneapolis	
	Med. Sch. Country	List	099 USA
	Degree Code	MD	Doctor of Medicine
	Graduation Month/Year	06	1989
Exit Cancel Review			
Full Service - Page 1			
USMLE Step 3 Full Service Application Page 2 - V4.02.015- PDRDB			
File Edit Fee Additional Info			
Name	Grant	Batch ID	Seq. No. Req. ID 16325223
Name	Carrol Earl		
Application Information - 1		Application Information - 2	
9.	Participation Flag	Future Start Date Month/Year	Date Program Started Month/Year
	Yrs Completed	From Month/Year	To Month/Year
	Program Code	16	Internal Medicine
10.	Specialty Code		
11.	Identification Numbers		
	ECFMG		
	FLEX		
	NBME		
	USMLE	40407067	
13.	Address Line1	PO Box 551	
	Address Line2		
	Address Line3		
	City	Fort Worth	State/Prov TX Zip/Postal Code 76102
	Country	List	099 USA
	Phone	E-mail GRANTSG3@EXCITE.COM	
15.	Ethnic Background	English Native Language	
14.	<input checked="" type="checkbox"/> Release of Step 3 data - Applicant does NOT wish to have scores reported to their school.		
16.	<input checked="" type="checkbox"/> Test Accommodations - Applicant requested for Test Accommodations.		
	<input type="checkbox"/> Request Practice CD - Applicant requested for Practice CD to be mailed to them.		
Exit Cancel Review			
Full Service - Page 2			

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USMLE	<u>4-048-306-7</u>	ExamFile	<u>404-83-06</u>
State	<u>033</u>		
User	<u>AMP</u>		
req_id	<u>17671164</u>		
web	<u>161007</u>		
daterec	<u>03/20/07</u>		
Name	<u>Carrol Earl Grant</u>		
SSN	<u>416049575</u>		
DOB	<u>09/16/53</u>		
Grad Date	<u>Jun-99</u>		
PB	<u>BBM</u>		
datecreated	<u>03/21/07</u>		

Circle or Check off list	
Check for Data entry USMLE number	<u> </u>
Degree Verified <u>Yes</u> /No MM/YR <u> </u> / <u> </u>	
5th Pathway/ECFMG Yes/No Date <u> </u>	
Exam file # Entered and Correct with file at top/side and USMLE # <u> </u>	
Check for Registration Initials <u> </u>	
<input checked="" type="checkbox"/> Passed Step 1	Step 2CK <u> </u>
Step 2CK after 7/1/05	Step 2 CS <u> </u>
2005 or above	Step 2 CS <u> </u>
IMGs	Step 2CS or CSA <u> </u>
Check Loose Documents <u> </u>	
Previous valid CIF <u> </u>	
Notes	

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDRDB

File Edit Fee Additional Info

Name Grant Batch ID Seq. No Req. ID 17671164

Name Carol Earl

Application Information - 1

1. State Board New York State Board For Medicine Assign User

App Date App Date Type Web Exam Code

2. Attach

3. Last Name
Rest Of Name Carol Earl
Generational Suffix

4. Date of Birth 09 16 1993 (mm/dd/yyyy)

5. US Social Security No. 416840575
National ID Number
National ID Country List

6. Gender M

7. Citizenship Cntry List 099 USA

8. Med. School of Grad List 02433B
University of Minnesota Medical School - Minneapolis
Med. Sch. Country List 099 USA
Degree Code MD Doctor of Medicine
Graduation Month/Year 06 1999

Exit Cancel

Full Service - Page 1

USMLE Step 3 Full Service Application Page 2 - V4.02.015- PDRDB

File Edit Fee Additional Info

Grant Name: Carol Earl Batch ID: Seq. No: Req. ID 17671164

Application Information - 1 Application Information - 2

9. Participation Flag ☒ Future Start Date Month/Year: From Month/Year 06 1999 To Month/Year 06 2002
 Yrs Completed 3 Program Code 16 Internal Medicine

10. Specialty Code 07 A - Internal Medicine

11. Identification Numbers
 ECFMG _____
 FLEX _____
 NBME _____
 USMLE 40403067

13. Address Line1 P O Box 551
 Address Line2 _____
 Address Line3 _____
 City FORT DUNSMuir State/Prov KY Zip/Postal Code 13602 List
 Country List 099 USA
 Phone _____ E-mail grant965@excite.com

15. Ethnic Background _____ English Native Language ☒

14. ☒ Release of Step 3 data - Applicant does NOT wish to have scores reported to their school.
☒ Test Accommodations - Applicant requested for Test Accommodations.

16. ☐ Request Practice CD - Applicant requested for Practice CD to be mailed to them.

Full Service - Page 2

34

USMLE	<u>4-048-306-7</u>	ExamFile	<u>404-83-06</u>
State	<u>033</u>	cd request:	<u>N</u>
User	<u>AMP</u>		
req_id	<u>19205498</u>		
web	<u>232205</u>		
daterec	<u>04/15/08</u>		
Name	<u>Carrol Earl Grant</u>		
SSN	<u>416049575</u>		
DOB	<u>09/16/53</u>		
Grad Date	<u>Jun-99</u>		
PB	<u>RDB</u>		
datecreated	<u>04/16/08</u>		

Circle or Check off list

Check for Data entry USMLE number

Degree Verified Yes/No MM/YR /

5th Pathway/ECFMG Yes/No Date

Exam file # Entered and Correct with file at top/side and USMLE #

Check for Registration Initials

Passed Step 1	Step 2CK
Step 2CK after 7/1/05	Step 2 CS
2005 or above	Step 2CS or CSA

Check Loose Documents

Previous valid CIF

Notes for 0801 Adphin

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDR08			
File Edit Fee Additional Info			
Name	Grant	Batch ID	Seq. No. Req. ID 19205498
Name	Carrol Earl		
Application Information - 1		Application Information - 2	
1.	State Board	New York State Board for Medicine	Assign User
	App Date	App Date Type Web	Exam Code
2.	Attach	For	
3.	Last Name		
	First Name	Carrol Earl	
	Generalized State		
4.	Date of Birth	09 16 1993 (mm/dd/yyyy)	
5.	US Social Security No.	416049573	
	National ID Number		
	National ID Country	List	
6.	Gender	M	
7.	Citizenship Cntry	List	099 USA
8.	Med. School of Grad.	List	024030
		University of Minnesota Medical School - Minneapolis	
	Med. Sch. Country	List	099 USA
	Degree Code	MD	Doctor of Medicine
	Graduation Month/Year	06 1999	
<div> <div>Exit</div> <div>Cancel</div> <div>Save</div> </div> <div>Full Service - Page 1</div>			

USMLE Step 3 Full Service Application Page 1 - V4.02.015- PDR08			
File Edit Fee Additional Info			
Name	Grant	Batch ID	Seq. No. Req. ID 19205498
Name	Carrol Earl		
Application Information - 1		Application Information - 2	
1.	State Board	New York State Board for Medicine	Assign User
	App Date	App Date Type Web	Exam Code
2.	Attach	For	
3.	Last Name		
	First Name	Carrol Earl	
	Generalized State		
4.	Date of Birth	09 16 1993 (mm/dd/yyyy)	
5.	US Social Security No.	416049573	
	National ID Number		
	National ID Country	List	
6.	Gender	M	
7.	Citizenship Cntry	List	099 USA
8.	Med. School of Grad.	List	024030
		University of Minnesota Medical School - Minneapolis	
	Med. Sch. Country	List	099 USA
	Degree Code	MD	Doctor of Medicine
	Graduation Month/Year	06 1999	
<div> <div>Exit</div> <div>Cancel</div> <div>Save</div> </div> <div>Full Service - Page 1</div>			

35



FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.

2004-2005
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SERVICES
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September 7, 2004

C. Earl Grant, MD
HHC 18th MEDCOM
Unit # 15281, Box # 872
APO, AP 96205-5281

I am writing in response to our recheck request for your July 21-23, 2004 Step 3 exam.

The fee for the recheck is \$50.00. I received a check from you, (check number 1536, dated August 30, 2004) in the amount of \$25.00. In order to process the request, I will need to receive an additional \$25.00. Once I receive the full amount, I will forward your request for a recheck. Please keep in mind that the cutoff date for requesting the recheck is November 16, 2004.

If you should have any other questions, please contact me at 817-868-4041 or via email.

Sincerely,

Sandy McAllister

Sandy McAllister
Administrative Assistant
Examination Services

File # 40483067

CR # 1536 25.00
1537 25.00

7/21/04 0401 JRL
sent 8/18

36

RECEIVED AUG 17 2006

P.O. Box 551
Fort Drum
NY 163602
August 13, 2006

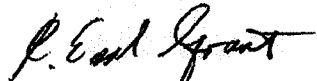
ATTN: Mr. David Johnson/Debra Cusson
Exam Dept/Step 3
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039

Dear Sir/Madam:

In reference to the USMLE Step 3 examination taken by me in July, 2003, December, 2004, and July, 2005, I hereby formally request that a hand-scoring of the USMLE examinations be done immediately and the result forwarded to me at the above address.

I am enclosing a check in the amount of \$150.00, the required fee for the hand-scoring. I anticipate a formal reply within the projected time frame stipulated in your information Bulletin. I further request that the names of the personnel responsible for the re-grading and reporting of the scores be provided with your results for accountability.

Respectfully,



C. Earl Grant, M.D., Ph.D.

cc: Mr. Clifford Hark
Rosemary Antonacci

40483067

37



August 21, 2006

C. Earl Grant, M.D., PhD.
P.O. Box 551
Fort Drum, NY 13602

Dear Dr. Grant:

I have received your request for a hand rescore of your July 2003, December 2004 and July 2005 Step 3 examinations.

Standard procedures ensure that the scores reported for you accurately reflect the responses recorded by the computer. A change in score based on a recheck is an extremely remote possibility. However, requests for score rechecks must be received no later than 90 days after your score report release date. Unfortunately, we are well beyond this time frame to perform the rechecks you are requesting.

Enclosed you will find your personal check for the rescore fees. I am also providing you with copies of the USMLE Bulletin of Information for the examination dates above. I have highlighted the areas concerning the rescore request process.

Should you have further questions, please contact me at 817-868-4025 or via e-mail at dcusson@fsmb.org.

Sincerely,


Deborah Cusson
Supervisor, Registration Services

Enclosure

38

NO 8
LFS

P.O. Box 551
Fort Drum
NY 13602
July 25, 2007

RECEIVED JUL 30 2007

408 3061

ATTN: Mr. David Johnson/Deborah Cusson
Exam Dept/Step 3
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Eules, TX 76039

Dear Sir/Madam:

In reference to the USMLE Step 3 examination taken by me on November 1-3, 2006, I hereby formally request that a hand-scoring of that USMLE examination be done immediately and the result forwarded to me at the above address.

I am enclosing a check in the amount of \$50.00, the required fee for the hand-scoring. I anticipate a formal reply within the projected time frame stipulated in your information Bulletin. I further request that the names of the personnel provided with the answer keys and the test responses, and who will be responsible for the proper re-grading and reporting of the scores be provided with your results for accountability.

Respectfully,

C. Earl Grant, M.D., Ph.D.
C. Earl Grant, M.D., Ph.D.

cc: S. Berg

39



August 2, 2007

C. Earl Grant, M.D., PhD
P. O. Box 551
New York, NY 13602

Dear Dr. Grant:

I have received your July 25, 2007, request for a hand rescore of your November 1-3, 2006 Step 3 examination.


Standard procedures ensure that the scores reported for you accurately reflect the responses recorded by the computer. A change in score based on a recheck is an extremely remote possibility. However, requests for score rechecks must be received no later than 90 days after your score report release date. Unfortunately, we are well beyond this time frame to perform the recheck you are requesting.

Your letter indicated that you had enclosed a check for the rescore, unfortunately no check was found with your letter request. I was unable to cc: S. Berg as no address was provided.

Enclosed you will find a copy of the USMLE Bulletin of Information for the examination dates of November 1-3, 2006. I have highlighted the areas concerning the rescore request process

Should you have further questions, please contact me at 817-868-4025 or via email at dcusson@fsmb.org.

Sincerely,


Deborah Cusson
Supervisor, Registration Services

Enclosure